Self Directed Support Assessment and Care and Support Planning Practice Guidance
Derbyshire County Council - Adult Social Care

If you would like to make any comments, amendments, additions etc please email ASCH.adultcare.policy@derbyshire.gov.uk

Derbyshire County Council Adult Social Care publishes a range of practice guidance documents to support workers when implementing council policies in their work with adults with care and support needs, in this case, the Adult Social Care Self Directed Support (SDS) Policy.

They are written in plain language and give clear guidance detailing how professionals and other relevant parties should respond when doing **assessments and care and support planning**.

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Introduction

The overarching Adult Social Care Self Directed Support Policy includes the underpinning legislative background arising from the Care Act 2014 and provides the framework for assessment and care and support planning to which this practice guidance relates. It applies to all Adult Social Care staff involved in this work. Links to relevant additional policy and guidance documents are located throughout this document.

Carers guidance has been developed separately which is compliant with the duties contained in the Care Act 2014.

Our approach to self-directed support is regularly reviewed, including feedback from key stakeholders (mainly clients and staff) and so workflow procedures are adjusted to streamline the process. Therefore, reference is frequently made to procedural guidance available within the Casework Management System (CMS) rather than duplicating it within this document.

Working in a person centred way will ensure that a person's personal priorities will be accurately captured in whatever setting and at every stage of the process. A clear set of simple and measurable outcomes can be identified that inform the basis of any care and support plan.

In line with the Dignity Policy, all people using services can expect to be treated in a manner which maintains, promotes and upholds their dignity.

Derbyshire County Council retains its duty of care, safeguarding and risk management responsibilities and other statutory duties. For further details please see the safeguarding adults at risk policy and procedures which can be found on the Safer Derbyshire website.

For guidance on making eligibility decisions please see separate worker guidance on determining eligibility.

Guiding Standards

Helping people to establish self-directed support depends on working in a person centred way consistent with the principles originally outlined in the Care Act 2014. This includes the duty to promote wellbeing.

Adult Social Care staff will:

- provide people with relevant information leaflets in their preferred format to enable them to participate as fully as possible
- comply with relevant legislation and departmental policies including for example, the Recording Policy and Procedures, Direct Payment Policy, Human Rights Act 1998, Equality Act 2011, Data Protection Act 1998, Mental Capacity Act 2005,

Disability Discrimination Act 1995

- through a 'Think Family' approach, identify and take account of the contribution and impact on the wellbeing of informal carers including consideration of the needs and support requirements of young carers - see also carers support – worker guidance
- use the 'first person' within assessment and care and support plans unless there are specific reasons for this to be inappropriate. Where use of the 'first person' is inappropriate, the source of information and a description of how the person has been involved should be provided
- using a 'strengths-based approach', ensure that assessment identifies and seeks to mobilise the person's individual strengths, resources, existing networks, community and sustainable on-going support
- adopt the principles set out in the 'Better Lives' transformation programme which seeks to deliver personalised outcomes in the most independent setting
- ensure that the person's views, wishes and 'what's important to and for' them are understood and that they can contribute to the assessment process. Where appropriate, this includes consideration of the involvement of independent advocacy services - see guidance here
- assessments should include carers and be coordinated across local agencies. Information should be sought from other specialists where necessary to improve the quality of assessment
- assessments should seek the views of staff from provider agencies who may have built up detailed knowledge of the client over a period of time
- seek to achieve agreement with the client on their outcomes and priorities identified in the assessment, which will inform the care and support planning
- the assessment should be proportionate and led by the person and/or their carer/advocate - the exception is where there are third party concerns, identified either in the original referral or subsequently identified by the assessor or other involved persons
- the assessment should be both descriptive and analytical - as well as evidencing the application of strength-based approaches which may enable outcomes to be achieved, it should evidence the reasons for any decisions in a clear and concise manner
- seek to achieve a consensus on how things are recorded or, where this is not possible, clearly record where the differences of opinion are - for fuller guidance on recording practice please see Adult Social Care Recording Policy and Procedures
- make sure that people know who to contact
- deal with any complaints or concerns and seek to resolve these whilst ensuring people know how to comment or complain about decisions made and/or the services they get. Ensure you make a complaints leaflet available

Purpose of Assessment

The purpose of an assessment is to:

- get a good understanding of the person's situation, what they are working toward, their strengths, abilities, resources and potential, as well as their care and support needs
- help people to think about the outcomes that are important to and for them now and in the future.
- identify opportunities so the person can be as independent as possible for as long as possible
- identify the person's own strengths, capabilities, along with any strengths and assets in their wider networks and communities and how these can support them to achieve their goals
- respond to the person's needs and promote their wellbeing. - these opportunities make the best use of professional intervention, and use of ordinary solutions including universally available resources
- identify how these needs impact on their wellbeing
- listen to what people want from their lives
- inform decisions about eligibility for the provision of funded care and support, including the provision of short-term support to reduce or avoid the need for care and support

Where eligible for the provision of funded care and support to meet assessed needs that can't be met in any other way, the assessment forms the basis of delivery for council funded services

Where people are eligible for a personal budget, through its link with the resource allocation system, assessment also supports the calculation of an indicative budget. This is the essential starting point to help the person or their representative identify and develop realistic, cost effective and sustainable care and support solutions.

The Assessment

Assessments should be proportionate and carried out in as much detail as necessary. The complexity of the person's situation and the needs presented will determine what level of assessment is required, not the type of services requested at the time of referral.

An assessment should consider how to support the person to be as independent as possible for as long as possible (See the Care and Support Statutory Guidance).

For people with fluctuating needs, it will be necessary to consider levels of need over a sufficient period of time to gain a complete picture of those needs, and to understand the implications of their condition and circumstances.

A 'Think Family' approach should be taken at all times throughout the process with consideration being given to the impact of the person's needs on their family and support network. This involves identifying anyone, including children and young people, who may be part of the wider network of care and support. This is a requirement within the Children and Families Act 2014.

'Strengths-based assessment' is a term that can be used interchangeably with 'asset-based assessment'. It refers to different elements that help or enable a person to deal with challenges in their life, and more particularly, in meeting their needs and achieving their desired outcomes.

They may include:

- personal resources such as abilities, skills, knowledge, potential etc.
- their social network and its resources, abilities, skills, etc
- community resources, also known as 'social capital' and/or 'universal resources'

Further guidance on a strengths-based approach is available on the Social Care Institute for Excellence (SCIE) website.

Overall, the approach to assessment will fulfil six basic requirements.

1. It will enable a proportionate approach to assessment and care and support planning.
2. It will establish the person's capacity for involvement in the assessment and care and support planning process and consider, if appropriate, the need for Independent advocacy as well as confirming whether there are any issues relating Deprivation of Liberty Safeguards (DOLS), Lasting Power of Attorney (LPA) and Court of Protection.
3. It will ensure that the universal offer and access to early intervention (consider using the first contact scheme) and prevention occurs at the earliest possible point in our engagement with each person.
4. It will provide a professional recommendation as to what would enable the person to live as independently as possible for as long as possible.
5. It will ensure that a secure eligibility judgment is made at the earliest possible point.
6. It will ensure that the generation of an indicative budget is undertaken only when all the opportunities available to people to deal with their social care needs via universal services and community resources have been explored.

For people with learning disabilities, and others where appropriate, this will include consideration of a completed 'This is Me Plan'.

In addition to the standard assessment forms, it may be necessary to complete

additional or alternative assessments to get a full picture of the person's situation. Some of these may need to be completed by, or with, the support of other professionals. A range of assessment tools are available within the casework management system via 'procedural help' together with guidance on how to use them.

People who are Deafblind

If there is an appearance of both hearing and sight loss, you will need to consider whether the person is deafblind. People are deemed to be deafblind:

'if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss.'

(Department of Health (1997) Think Dual Sensory: Good practice guidelines for older people with dual sensory loss).

When assessing people who are deafblind you must ensure that you consult with an expert in deaf blindness and record their involvement. Each area has a nominated sensory worker who has undergone specialist training and is able to undertake assessments with deafblind people or to advise and guide you in this area of work. Where interpreters are required for example, with adults using sign language, the deaf services team will undertake the assessment.

Separate practice guidance is also available – Sensory Disability– Dual Sensory Loss/Deafblind Practice Guidance.

Consent and Limitations to Sharing Personal Information

To comply with the Data Protection Act 1998 and other information governance legislation and policies, it is important that the need to appropriately share information when arranging care and support is clearly explained to people, and their consent to do so is obtained. You should establish and record what, if any, limitations have been agreed. An appropriate warning marker needs to be added on the Casework Management System (CMS).

Assessment Quality

Staff at all levels are responsible for the quality of their assessment, and service managers and senior practitioners will provide management and professional support. This includes ensuring that:

- there is evidence of a person centred approach – a good sense of who the person is and what is important to and for them etc
- the person's goals, desired outcomes/what they are working toward are identified
- opportunities to maximise the person's independence have been considered

- the assessment evidences use of strength-based approaches with a graduated approach, including as a starting point the use of ordinary/mainstream solutions - moving on to universally available resources/ low level equipment - progressing to more specialist equipment including appropriate use of assistive technology
- a 'Think Family' approach has been used which identifies the impact on the family of a person's care and support needs
- the eligibility decision has accurately considered relevant information
- the appropriate assessment documentation has been used including associated risk assessments.
- evidence the consideration of the use of short term reablement services and record why these have not been appropriate
- evidence of use of multi-disciplinary peer group discussions
- For people going on to require a personal budget the assessment has been accurately scored and there is a match with the narrative

Assessment in Emergencies

In emergencies, services can be provided to an adult before a formal assessment is completed. In these situations, **the assessor should:**

- act quickly
- utilise available information, with the approval of the relevant manager, set up services and undertake episode/form/case note completion within the casework management system
- begin a formal assessment within 3 working days
- advise the individual that a more detailed needs assessment/process will follow

Care and Support Planning

Care and support planning and completion of the plan can be undertaken by the person or their representative independently, with the support of other people of their choosing, or with Adult Social Care worker support.

The emphasis is on identifying appropriate creative solutions to each person's support needs and achieving greater independence and social inclusion for people within their communities.

Generally, the standard plan template **'core support plan'** is available within the CMS.

However, this will not be suitable for everyone so alternative care and support plan formats and styles that the individual will understand and which suits their needs and preferences

should be used. However, there are clear benefits to completing the standard support plan document within the casework management system as it will enable retrieval of information.

Care and Support Plan Content/Sign-off

Whoever completes the plan and whatever format it is presented in, the plan must include:

- the outcomes identified by the assessment
- information and advice on what can be done to reduce the needs in question, and to prevent or delay the development of needs in the future
- whether, and to what extent, each of the outcomes meet the eligibility criteria or collectively whether there is a significant negative impact on wellbeing
- the outcomes that the person, their carer, and/or network/community will meet
- the outcomes it is necessary for the authority to meet, and how it intends to do so
- a personal budget
- where needs are being met via a direct payment, the needs to be met via the direct payment and the amount and frequency of the payments

In all cases the care and support plan will need to reflect what is **important to and for** the person **as well as** include details of:

- how any risks will be managed
- how their support will be managed in unforeseen circumstances including fluctuating or changing needs, ill health - and should include a robust contingency plan
- how the person will make decisions and stay in control of their life

When necessary, personal ambitions and preferences should be identified separately to professional judgments about what the Council should do for someone.

It is not appropriate to sign-off a plan without this information as the Adult Social Care worker will be **unable to judge whether the plan is**:

- likely to be appropriate and realistic to meet the assessed eligible social care needs;
- a suitable and legal way to use the budget or that it will keep the person as safe and well as possible in the circumstances - having regard to their mental capacity

People Completing their own Plans (or Supported by Non-Adult Social Care Assessors)

Work is ongoing with stakeholders to develop a range of information and support tools to help people to complete their own plans.

Adult Social Care Assessor Completion of the Plan

Guidance for workers when completing the core support plan is available within the casework management system form. Some elements are given further consideration here.

Advance Decisions

This is a key area and the existence of this should also be entered separately within the casework management system as a warning note.

Supporting People to Remain Involved and in Control

Whilst many people may not require any support to make some or all decisions, others may prefer to consult family members or friends about certain decisions, and it would be helpful to identify these.

Some people may require more formal support. What has been identified as necessary should be indicated, to ensure the person has been, and remains, involved in all aspects of their life, and supported to make decisions.

Typical examples include:

- access to independent advocacy and advice
- use of an interpreter
- information and documentation in an appropriate format/language
- location and environment where meetings take place
- important routines such as attendance at clinics/support groups without which the person's ability to engage with the wider community would be compromised

Further guidance on independent advocacy is available here.

People with a learning disability, Autism or Asperger's, including those residing in, or at risk of admission to inpatient psychiatric facilities

Details of, and signposting to, stay well plans arising from a community treatment review, should be incorporated into the overarching care and support plan.

Similarly, the existence of any specific health, risk or behavioural management plan for any client group should be referenced in the overarching care and support plan.

Contingency Arrangements

As well as ensuring that the person is clear who they should contact in certain scenarios, for example if their paid carer does not arrive as planned, it should include details of what the person would like to happen, what action is required, who needs to be contacted in particular circumstances, and how alternative assistance will be provided.

The plan must explain what contingency arrangements are in place and consider how their budget might be used flexibly to manage emergencies such as a need for unplanned respite or replacement care.

Confirming Budgets

The Resource Allocation System (RAS) is designed to produce a reasonable/realistic Indicative Budget (IB) for most of the people most of the time. As such it is a good starting point for the person to develop their care and support plan.

The persons final Personal Budget (PB) i.e. the amount they will receive to fund their care, will only be confirmed at the point that a care and support plan has been agreed. The care and support plan which provides safe sustainable care and support that meets their assessed unmet eligible needs and related outcomes.

There will be occasions when the IB needs to be adjusted (either up or down) based on professional judgement to ensure that the final PB is sufficient (but no more so) to enable a robust care and support plan. This adjustment is typically made toward the end of the care and support planning process if it becomes clear that the starting IB was insufficient or overgenerous. In some circumstances however, it may be necessary to adjust the IB prior to this activity commencing. Any differences from the initial IB and the final amount, deemed essential to deliver a safe and sustainable care and support plan, should be recorded on the IB/PB mismatch form.

You should always try to seek agreement with the person on both their assessment and resulting care and support plan. The following are key things to consider.

1. Whether the assessment has considered all the relevant information pertaining to that person.

2. Whether the assessment has given sufficient weight to particular pieces of information.

3. That the automated IB is a realistic starting point to begin the care and support planning process.

4. That the resulting care and support plan is robust, suitable, and can meet the person’s assessed unmet eligible needs and their associated outcomes.

However, if someone disputes this and remains strongly against the judgement that the IB/PB is reasonable and realistic, the review mechanism should be considered (see section 'Complaints and Challenges' below for guidance on the review mechanism).

Defensible Decision Making

Our objective is to make sure that wherever possible the outcome of the assessment and care and support plan leaves each person with safe and personalised care and support. They should feel the plan has given them as much choice and control as possible. We (the authority) should be confident it fulfils our statutory responsibilities and policy requirements as cost effectively as possible. Whilst every effort will be made to reach agreement, there may be occasions where this is not possible, and someone wishes to challenge a decision. It is therefore essential that professional and management decisions are defensible. It is particularly important that decision making is clear and openly shared.

Professional Judgement

The assessment and care and support planning approach depends on clear and coherent use of competent professional judgement by case workers.

It is essential professional judgements are clearly recorded, along with reasoning and decisions, and in a way that can be understood by the person involved and/or their representative(s). For example, a case worker might need to note ***"Whilst I appreciate that you disagree with the conclusion reached, it is my professional opinion that 24 hour 1:1 care is not needed to appropriately manage the likely risks involved***'. It is important that case workers have taken personal professional responsibility to distinguish between what is **important to someone** (their personal wishes/preferences) and what is **important for them** (the action which appears to be reasonable and necessary as an objective decision that should be taken by a reasonable local authority).

In some circumstances eligible outcomes may be met completely using strength-based approaches and universally available resources. Consequently, discussion with clients and carers should not focus on whether a particular service can be purchased but rather whether it is realistic that the agreed eligible outcomes can be met through the strategies, resources and networks identified in the care and support plan.

Complaints and Challenges

Many people may prefer to carry on discussing the developing assessment and care and support plan and prefer not to move into the formality of the adjudication process set out in the complaints procedure. However, it is good practice to ensure that, whenever someone challenges a decision (indicative budget calculations or confirmed personal budget), we have informed them of the complaints process and invited them to use it if they so wish. This offer and response should be recorded

clearly in the case notes, and in some cases, it might be helpful to confirm a discussion about this in writing.

They may prefer to continue with options such as the offer of reassessment, second opinions, meetings with the senior practitioner, service manager or group manager to discuss differences, and this is appropriate as part of our work to resolve the difference/difficulty.

Our complaints procedure allows people involved in self-directed support who are challenging professional decisions to have access to an adjudication process (see the Complaints Policy and Procedure). However, use of this adjudication process should be viewed as an option of last, rather than first, resort.

Regular discussions with people about the use of the complaints processes and a clear record of these discussions in the person's case notes will provide strong evidence to demonstrate that we have taken concerns/complaints seriously. This will be important should the complaint escalate and be referred to the Local Government Ombudsman (LGO), which is a choice a person is entitled to make at any time.

If Someone Registers a Formal Complaint - SDS Adjudication Panel

The use of the SDS Adjudication Panel, within the complaints process will, in all cases, only be used once all opportunities for continued discussion with the person have been exhausted. Group managers will, in all cases, discuss the potential to offer an SDS Adjudication Panel with the complaints manager prior to making that suggestion to the client involved. In turn, the complaints manager will discuss the case with the appropriate assistant director.
This level of agreement will help to confirm that the expected good defensible decision making has occurred already, and, in the event of the appeals panel finding against the person involved and the LGO becoming involved subsequently, the grounds would be minimised for the LGO to uphold a claim of maladministration against the Council.

Use of Direct Payments

Where someone is to take all or part of their budget as a direct payment it is vitally important to check that people fully understand and agree their responsibilities with regard to managing direct payments, both initially at the beginning of the process and regularly throughout the SDS process.

You will need to provide them with all relevant information about direct payments. It is expected that you are satisfied that the client understands the responsibilities of being an employer, as well as managing the administrative requirements of having a direct payment, e.g. the regular submission of financial returns to Adult Social Care.

There is comprehensive Direct Payment Policy And Procedural Guidance available separately – see also, for example, the Direct Payments Good Practice Guide available on the public website.

See also the SDS Care and Support Plan Review Practice Guidance for expectations at review.

A clear link should exist between the type of support and how it supports the achievement of the individual's outcome(s).

The option for a client to take their budget wholly or in part as a direct payment is available ***at any time*** to assist people to achieve self-directed support.

Websites

Social Care Institute for Excellence (S.C.I.E.) website

Author History

Approval and Authorisation History

Name:	Job Title	Date:
Authored by Jenny Hudson	Service Manager	June 2013
Approved by: Roger Miller / Dominic Sullivan	Group Managers	July 2013

Change History

Version	Date	Name	Reason
Version 1	June 2013	Jenny Hudson	Development of new practice guidance
Version 2	March 2015	Jenny Hudson	Review to absorb Care Act 2014 requirements
Version 3	July 2017	Jenny Hudson / Dominic Sullivan	Review
Version 4	May 2021	Josie Hill / Dominic Sullivan	Review Amendments to sections 3,4,5,7